DISCHARGE PLANNING PRACTICES WITH HOSPITAL PSYCHIATRIC PATIENTS

by

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FINAL READING APPROVAL

To the Graduate Council of the University of Utah:

I have read the thesis of Duane D. Walker in its final form and have found that (1) its format, citations, and bibliographic style are consistent and acceptable; (2) its illustrative materials including figures, tables, and charts are in place; and (3) the final manuscript is satisfactory to the Supervisory Committee and is ready for submission to the Graduate School.

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ABSTRACT

This study was done to determine what written documentation exists in the psychiatric patient's record after discharge from the University of Utah Medical Center that indicates and supports the premise that there is discharge planning of appropriate quality to withstand the scrutiny of objective review by external monitoring and regulating agencies.

The purpose of this study was to determine the type of planning that took place and was documented prior to the patient being discharged, thus providing a data base for the development of criteria for a quality assurance program for psychiatric patients. Determination of the outcomes of such a program is dependent on such a data base. The survey of psychiatric patients' charts was designed to determine what specific activities occurred over a three month period, and were documented, relative to planning for a patient's discharge from the hospital. What was recorded in the patient's record that reflected and documented the University of Utah Hospital's discharge planning program? It was considered that this information would provide baseline data upon which more discriminatory studies could be designed in the future.

The research design was a retrospective study in the form of a survey of information in the patient's chart to identify the

clinical material available for use as guidelines for discharge planning programs. The survey included admission data and discharge data. Standard hospital record forms were used to determine what information had been obtained from patients. Discharge notes of physicians, nurses, and other members of the professional team were reviewed and the information was categorized.

The admission data were complete for the 79 patients with regard to demographic information of sex, age, residence, religion, and marital status, and the time of day and type of admission. A total of 29, or 36%, of the 79 charts did not have educational level information and 17, or 22%, of the 79 charts did not have present employment data.

The discharge data showed 39, or 49%, of the 79 patients had one or more leaves of absence before their discharge from the hospital. Information available on follow-up referral of the 60 Salt Lake City and County patients showed 17, or 29%, had an appointment to see a private psychiatrist; 31, or 52%, were referred to a community mental health center; 5, or 8%, to alcohol rehabilitation programs; 5, or 8%, to the Utah State Hospital; and 2, or 3%, were discharged against medical advice. Forty-seven patients, or 60%, were discharged on major or minor tranquilizing medications. Only 10, or 12%, of the 79 charts reviewed had documentation with regard to patient teaching.

Examination of the discharge diagnosis of the patients revealed that 32% were diagnosed as having schizophrenia, 21% depression,

12% personality disorders, 6% drug and alcohol abuse, and 26% had no discharge diagnosis. The data are significant in that characteristics of schizophrenic patients, especially in regard to their difficulty in establishing and maintaining relationships, need to be considered for a follow-up treatment program.

Implications for developing discharge planning programs for psychiatric patients were discussed and recommendations were made for future research.

CHAPTER I

INTRODUCTION

The purpose of this research was to determine what written documentation exists in psychiatric patients' charts after discharge from the hospital to support the premise that there is discharge planning of appropriate quality to withstand the scrutiny of objective review by external monitoring and regulating agencies.

The provision of health care in the United States has become the nation's largest industry, with a total yearly health expenditure approaching the $104 billion mark. In 1973, Americans spent $441 per capita or 7.7% of the gross national product on their health care needs, with the largest portion of this going toward hospital care (Cooper, 1974).

In view of the high cost of medical care, the health care industry is currently being bombarded with demands from many sources for quality assurance of their products. Delivery of health care, whether preventive, treatment of acute or chronic illnesses, or supervision of long term health problems, should result in individuals receiving the highest quality of health care for their dollar.

The definition of quality assurance involves evaluating the degree of excellence of the results of delivered care and taking

action to make improvements that in the future will result in a higher quality of care (Phaneuf, 1974). Quality is a distinguishing characteristic that determines the value, rank, or degree of excellence. In health care, there are many views of quality such as accessibility, acceptability, adequacy, appropriateness, effectiveness, and efficiency.

Zimmer (1974) stated:

> Assurance includes the acts of making sure and of giving confidence; thus quality assurance is the estimation of the degree of excellence in patient health outcomes, and the use of the results of estimation to secure improvements in order to fulfill the public trust that professionals continuously search for better means of health care. (p. 305)

There are many conflicting points of view from various groups regarding the most effective way to assure quality care; however, the current priority for quality assurance in health care was specifically stimulated by inclusion of quality control requirement in the Social Security Amendments of 1972 (Public Law 92-603, 92nd Congress, N.R. 1, Oct. 30, 1972, 101-117) and by the potential for similar requirements in future federal and state health care legislation. The Social Security Amendments of 1972 mandate the establishment of Professional Standards Review Organizations (PSRO'S) through which physicians will assume certain responsibilities for reviewing the appropriateness and quality of services provided under Medicare, Medicaid, and Maternal and Child Health Programs (Sullivan, 1974).

The Social Security requirements include demands for cost analyses of health services, especially in relationship to the

utilization of facilities. In Utah this demand is fulfilled by the Utah Professional Review Organization (UPRO) which has developed a technique for establishing the appropriateness of admissions, the appropriateness of the level of care, and the appropriateness of the length of stay for patients funded by government programs, and for private health insurance companies under contractual agreements with UPRO (Utah Professional Review Organization, 1973).

In addition to government intervention in quality control of health care, the Joint Commission on Accreditation of Hospitals has been a strong influence for improvement of patient care. The Joint Commission accredits hospitals on a voluntary basis and holds to the principle that voluntary care systems can best serve the public, patients, hospitals, and health care professionals (PEP Primer, 1975). It has taken an active role in encouraging institutions to set up their own quality assessment mechanisms in response to public demand. Should the demand for accountability fail to achieve the required response on a voluntary basis, government intervention is likely to impose more regulations which may be less effective, more expensive, and less desirable than self-regulation of health professionals.

Currently, the Joint Commission has a nursing division facilitating nursing audit of patient outcomes by conducting workshops on nursing audit including specific methods and forms which have been developed. Outcome criteria for patients with a specific disease entity are decided by staff nurses. These criteria are then used in auditing patients' charts after discharge. The results are then presented to the staff nurses who in turn plan corrective action

for the deficiencies in regard to the stated criteria. For example, documentation of patient teaching could represent several problems such as a problem of not recording the teaching done in the patient's chart, or a lack of knowledge in the process and content of patient teaching. Consequently, actions to correct such problems are planned and evaluated in a repeat audit.

A future recommendation of the Joint Commission will be for audits of patient outcomes to be done on a joint basis between nursing and medical professionals. Some concerns about joint audits have to do with the differing primary function of each profession. Although the medical and nursing professions share concern for the patient as a unique human being, their primary concerns and functions differ. The nurse's primary concern and function is that of helping each person attain his highest possible level of functioning and general health; the physician's primary concern and function is the diagnosis and treatment of illness (Schlotfeldt, 1973).

Schlotfeldt's (1973) statement identifies an aspect of difference between the professions that may explain the difficulty of assessing "quality" of nursing care. That is, the major concern and function of nursing is less tangible and less concrete than that of medicine. The goals of medicine are time-limited while those of nursing are not. It can be questioned then whether the goals of nursing can be measured in terms of quality assurance. Consequently, this study was undertaken to look at discharge planning that included all health professionals. The goal was to begin to look jointly at quality assurance programs and at the contributions of

the various professional groups which might have been subject to written documentation in the patients' records. It was considered that determining such baseline data was preliminary to development of more discriminatory studies in the future.

In September 1973, the American Academy of Nursing took the position that nurses should be included in the quality assurance review organizations and should develop outcome criteria as a next step to standards of practice. For years registered nurses have believed that evaluation is an essential step in the nursing process. Nursing services and organizations have made many contributions to the literature on standards and evaluation programs for nurses, such as the American Nurses' Associations' delineation of the generic and specialty standards of practice and their implementation, and the emerging focus on the nature and purpose of peer review (ANA, 1973).

The Medicus Corporation has developed nursing quality assurance studies in regard to the structure and process of nursing care within hospital settings. Currently, studies are being conducted relative to how the nursing process affects patient outcomes (Medicus, 1974; WICHEN, 1975).

Of particular interest is the need for quality assurance in the field of mental health. Approximately 25% of hospital beds in the United States are filled by psychiatric patients. Quality assurance programs for psychiatric patients have not been developed to the same degree as other programs of quality assurance. The Joint Commission of Accreditation of Hospitals is working on methods of audit

for long-term psychiatric patients but has not begun to implement these programs. The American Nurses Association has developed standards of practice for psychiatric nursing; however, there is little documentation in the literature that indicates standards of nursing care have been implemented for psychiatric patients.

Quality assurance cannot be totally measured until there is a surveyed data base upon which criteria can be developed. A beginning data base for a quality assurance program for psychiatric patients should include evidence that appropriate planning regarding the patient's discharge from the hospital occurred before he was discharged.

Comprehensive care includes having professionals in hospitals responsible for patients in regard to their going home and maintaining their health status (JGAH, 1970). Discharge planning is an important aspect of this responsibility. Discharge from a psychiatric hospital or in-patient service can be an anxiety provoking experience due to stigma toward psychiatric patients and the fear of recurrent symptoms resulting in further psychiatric hospitalization. Therefore, this research looked at a beginning quality assurance program for psychiatric patients as it relates to discharge planning.

Primary consideration in this study was given to the following questions: (1) What admission data are available in the in-patient record? (2) What constitutes discharge planning, including professional follow-up? (3) Is there evidence of patient teaching in the chart? (4) Is there documentation in the patient's record

24 hours prior to discharge about his behavior and appearance?

(5) Is there evidence that the patient and his family were involved in planning for discharge?

CHAPTER II

METHODOLOGY

The University of Utah Hospital Medical Center has a bed complement set at 305. The psychiatric nursing unit consists of 28 beds and has a projected census of 8,030 patient days for 1975-1976 (University of Utah Budget Document--approved May 1975). The University of Utah Hospital is projecting an occupancy of 84.2%, 10,783 admissions, and a length of stay of 8.71 days for 1975-1976. The patient census for 2 West (Psychiatry) for the fiscal year 1974-1975 was approximately 90% occupancy with the average length of stay 12.1 days.

Psychiatric admissions to the in-patient unit consist primarily of people with problems of attempted suicide, anxiety states, drug abuse, depression, schizophrenia, psychosis, and alcoholism.

The psychiatric nursing unit is managed by a head nurse whose preparation is a Master of Science degree in Psychiatric Nursing. Clinical specialty support consists of two nurse clinical specialists who are involved with the Crisis Team, in addition to providing consultation to patients, their families, and the nursing staff. Also involved as providers of nursing care are professional nurses, licensed practical nurses, and nursing attendants. The unit is located on the second floor of the hospital and has a day room,

occupational therapy, kitchenette, semi-private rooms, and some ward facilities. The unit is divided, with 6-8 beds being provided as a closed or locked unit, including 2 seclusion rooms. The remainder of the beds employ an open concept with varying levels of patient privileges.

The Medical Staff consist of a Medical Director, Chief Resident, three residents, and medical students. Social workers and recreational therapists are also members of the team. Students from a number of colleges and departments of the University of Utah have clinical experiences on the unit at various times. Group and individual therapy are the primary treatment modalities.

The University Hospital is a component of the University of Utah Health Sciences Center which is concerned in achieving excellence in all its services and is committed in carrying out the following:

(1) The patient care programs are to provide the highest quality, patient-oriented care utilizing the most advanced knowledge, methods and techniques available for the diagnosis, treatment and rehabilitation of disease or injury. Highly specialized referral or tertiary care services are available along with primary and secondary care services commensurate with the needs of the state and region and the clinical educational programs of the health sciences.

(2) The Hospital's educational program is to provide a controlled clinical environment for the training of undergraduate, graduate, and post-graduate students of the Health Sciences Center

and of other colleges and health-related programs requiring clinical education for a degree or certification.

(3) University Hospital is to provide an environment for clinical research to advance the prevention and treatment of disease and injury.

(4) The Hospital is to engage in community service through continuing education for health professions and community education to advance and integrate contemporary health standards and health care services in the state and intermountain region (University of Utah Hospital Objectives, 1974-75).

The primary objective of the University Hospital, being committed to "excellence in providing the highest quality patient-oriented care utilizing the most advanced knowledge, methods, and techniques available for treatment" is supportive of surveying patient records to summarize existing discharge planning. One of the objectives developed by the University Hospital, Department of Nursing Services, is to design and implement a program for quality assurance in nursing care and to utilize research findings to develop the highest possible standards of care. To determine current activities which are occurring 24 hours prior to discharge would be valuable in evaluating present standards of care employed in discharge planning and establishing optimal standards. Quality of care is determined by identifying characteristics that depict the desired and valued degree of excellence and the expected observable variations (Zimmer, 1974). It is necessary to determine what the present activities are before moving to establish the expected

level of care.

The purpose of this study was to determine the type of discharge planning for psychiatric patients which was documented over a period of three months at University Hospital; thus, beginning to formulate a base for the development of criteria for a quality assurance program for psychiatric patients. The survey of psychiatric patients' charts was designed to determine what specific activities occurred relative to planning for a patient's discharge from the hospital. What is recorded in the patient's record that reflects the University of Utah Hospital's present discharge planning?

An initial step in the research project was a meeting on May 15, 1975 with the Clinical Specialists, Head Nurse, and two staff registered nurses on the psychiatric unit to explore the development of a method for surveying available discharge information. A survey tool was divided into Admission Data and Discharge Data. Standard hospital record forms were used to determine what information is obtained from patients (see Appendix A).

The research design was a retrospective study in the form of a survey of information in the patient's chart. Two research associates assisted in collecting and tabulating the data. Both associates had Masters degrees in Nursing with one having a degree in Psychiatric Nursing. The research associates had had experience in the process of nursing audit as well as in developing standards of care. Seventy-nine consecutive charts of patients discharged during the period from March 1975 to May 1975 were obtained from the Medical Records Department on June 9, 1975. Completed charts

were pulled in succession by the Medical Records staff. Data were obtained from the Admission Sheet, Progress Notes, Nurses Notes, and Discharge Summary,

CHAPTER III

RESULTS AND DISCUSSION

Sample

The sample consisted of 79 patients who had been discharged from the University of Utah Medical Center Psychiatric Unit between March 1, 1975 and May 1, 1975. There were 39 female patients and 40 male patients. The female patients were, on the average, somewhat older (mean age 41.79) than the male patients (mean age 32.95); however, the difference in age between men and women was not statistically significant (Table 1).

Research Questions

(1) What Admission Data are Available in the In-Patient Record?

Information as to sex, age, residence, religion, and marital status was complete for each of the 79 patients (Tables 1 and 2). Seventeen of the 40 male patients, or 42%, were single; compared to 4, or 10%, of the 39 female patients. Planning for the social and recreational needs of the single male patients, along with programs for the older, married female patients, should be considered in a quality care program at the University of Utah Medical Center. For example, activities on the University of Utah campus, such as movies, dances, and lectures, may be part of the in-patient

Table 1

Means, Standard Deviations, Frequencies, and Percentage of Subjects (79) by Age Groups and Sex (M = 40, F = 39)

Ages	Female N=39 Number	Percent	Men N=40 Number	Percent	Total Sample N=79 Total Number	Percent
0 - 20	2	5	4	10	6	7
21 - 30	7	18	20	50	27	34
31 - 40	13	33	9	23	22	28
41 - 50	6	15	2	5	8	10
51 - 60	7	18	2	5	9	11
61 - 70	4	11	3	7	7	9
Total	39		40		79	
Mean Ages	41.79		32.95		37.32	
Standard Deviation	13.62		14.57		14.71	

Table 2

Percentage of Subjects (79) by Marital Status and Sex
(M = 40, F = 39)

	Married		Single		Separated		Divorced		Widowed		Information Not Available	
	N=	%	N=	%	N=	%	N=	%	N=	%	N=	%
Female	19	49	5	10	--		11	28	2	5	3	7
Male	14	35	17	42	3	8	6	15	--		--	
Total N = 79	33	43	21	26	3	3	17	22	2	2	3	3

recreational program; thus, introducing patients to a social and recreational environment that would be productive in discharge planning. Documentation of such planning was lacking in the records reviewed.

There were minimal data on level of education, current employment, and occupational background which are categories of information needed as guidelines in developing discharge planning programs and for meeting quality assurance expectations. More complete data are needed. A total of 29, or 36%, of the 79 charts did not have educational level information and 17, or 22%, of the 79 charts did not have present employment data (Tables 3 and 4).

Excluding those for whom information was not available, the high school graduate category was the highest (17, 22%, N=79) in relationship to educational background (Table 3). Ascertaining the patient's level of understanding, before giving detailed information, may have implications for patient teaching and for other aspects of discharge planning for the psychiatric team. The stress of hospitalization emphasizes the importance of assuring that health teaching is comprehended. In referring to problems of patient teaching, Redman (1971) stated:

> Since teaching is goal-directed toward accomplishing particular learning, it is necessary to be able to identify goals that are appropriate to the situation and that the learner is likely to reach. (p. 573)

Knowing the level of education will help the psychiatric team member to evaluate the patient's learning ability and to plan specific content, thus aiding in developing a teaching protocol for him.

"Unemployment" was the highest category reported--relative to

Table 3

Percentage of Subjects (79) by Educational Background and Sex
(M = 40, F = 39)

	Less Than High School		High School Graduate		1-3 Years College		B.S.		M.S.		Information Not Available	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Female	6	16	9	24	3	7	4	10	1	2	16	41
Male	8	20	8	20	9	23	1	3	1	3	13	31
Total	14	17	17	22	12	15	5	6	2	2	29	36

Table 4

Percentage of Subjects (79) by Employment and Sex (M = 40, F = 39)

FEMALE N = 39

Housewife N =	%	Unemployed N =	%	Clerical N =	%	Professional N =	%	Information Not Available N =	%
9	23	10	26	5	12	5	12	10	20

MALE N = 40

Unskilled	%	Skilled	%	Semi Professional	%	Professional	%	Unemployed	%
3	7.5	7	17.51	4	10	--	--	16	40

Not available	%	Student	%
7	17.5	3	7.5

type of employment (Table 4). Ten, or 26%, of the 39 women and 16, or 40%, of the 40 men were unemployed. The difference between males and females is noteworthy, although approximately 23% of the females regarded being a housewife as a type of employment. Lack of information regarding the current employment status of 17 of the 79 patients in the sample is surprising at best. Referral for vocational training or job placement is frequently an important aspect of a quality care discharge planning program. For at least 20 years the importance of occupational rehabilitation programs for psychiatric patients has been emphasized in the literature (Greenblatt & Lidz, 1957). In an individualized psychiatric treatment program, patients may be assisted in obtaining employment while still hospitalized, may go to work during the day and may return to the hospital for night care. The nursing staff may than have an opportunity to help the patient in adjusting to his employment by assisting him to express his concerns about what happened during the day, and by evaluating the patient's capacity to work outside of the hospital.

The time of day and type of admission data were complete and available (Table 5). Out of 79 admissions, 37, or 47%, occurred on the evening shift and 62, or 79%, were unscheduled admissions. These findings have obvious implications for establishing optimum staffing on the psychiatric unit and for the crisis service in the emergency room for the evening shift (3:30 p.m. - 12:00 p.m.). Since 79% of all admissions were not scheduled, rooms on the psychiatric nursing unit should be kept available to accomodate the unscheduled or emergency admissions. The unit should be well staffed

for the evening hours in order to allow nurses to admit patients with acute problems which require intensive-care nursing. According to the current classification of patients by the nursing service of the University of Utah Medical Center, a patient with marked emotional needs, and/or who is disoriented, and/or is acutely psychotic, requires intensive nursing care which must be administered principally by a registered nurse and appropriately recorded.

Table 5

Percentage of Subjects (79) by Time of Admission and Sex (M=40, F=39)

	A.M.		P.M.		NOC	
	N=	%	N=	%	N=	%
Female N=39	10	25%	20	51%	9	23%
Male N=40	16	40%	17	43%	7	18%
Total N=79	26	33%	37	47%	16	20%

Thirty-two, or 41%, of the 79 patients had had previous psychiatric hospitalization. Twenty patients, or 25%, had been hospitalized before at the University of Utah Medical Center and 12 patients, or 15%, had been hospitalized at other hospitals. Surprisingly, information on hospitalizations from other hospitals was difficult to find in the patient's hospital record. This may have implications for cost and efficiency aspects of hospital utilization review, especially in

relationship to duplication of psychiatric tests and evaluations.

The type of former psychiatric treatment experiences may influence the current treatment program, especially in regard to the patient's own expectations. For example, the patient may expect to have a long-term hospitalization with minimal contact outside of the hospital environment. When he is asked to participate in obtaining employment or to join in community recreational activities, the patient may be hesitant to become involved. Ruesch, Brodsky and Fischer (1964) recommended that from the moment the patient enters a psychiatric hospital, his expectations and those of his family should be directed toward restoration of function and that discharge from the hospital is anticipated in the foreseeable future.

(2) What Constitutes Discharge Planning, Including Professional Follow-up?

For the purpose of this investigation, information on leave of absence, follow-up referral, discharge medication, and discharge diagnosis were noted.

Thirty-nine, or 49%, or the 79 patients had one or more leaves of absence before their discharge from the hospital. A leave of absence may be an important aspect of quality discharge planning in order for the patient to begin to make a transition from the hospital to his post-hospital living situation.

Most authorities agree that patients in transition generally experience varying degrees of anxiety as plans for their discharge are made. These anxieties may be deepened if the patient felt the community, in emphasizing responsibility and achievement, made

demands he was unable to meet. The patient may also be fearful of the stereotypes of the mental hospital held by others (Naboisek et al., 1957; Gralnick et al., 1961).

The problems encountered by the patient while on leave of absence may provide important information for discussion and supportive assistance upon his return from the leave of absence. Thus, the patient may actively participate in the evaluation of his own ability to cope with his emotions and to evaluate his decisions away from the hospital environment.

Information available on follow-up referral of the 60 Salt Lake City and County patients showed 17, or 29%, had an appointment to see a private psychiatrist; 31 patients, or 52%, were referred to a community mental health center; 5 patients, or 8%, to alcohol rehabilitation programs; 5 patients, or 8%, to the Utah State Hospital; and 2 patients, or 3%, were discharged against medical advice. Records of the 12 patients not residing in either Salt Lake City or County showed that 8 patients, or 66%, were referred to a private psychiatrist and 4 patients, or 34%, were referred to community mental health centers.

The 31, or 52%, Salt Lake City and County patients being referred to community mental health centers provide significant data for establishing discharge planning sessions involving the staff of the hospital with the local community facilities. Scheduled conferences between the professional staff may need to be arranged to exchange information about the patient and his treatment. The patient may need to participate in his discharge planning by meeting with the professional staff of the appropriate community mental health center in

order to understand and to agree to the type of treatment program planned for him after discharge. Ideally, the patient should have a leave of absence from the hospital to attend the community mental health center for a pre-arranged appointment.

Forty-seven patients, or 60%, were discharged on major or minor tranquilizing medications. What the patient was taught about the medication was not documented in the chart. In view of the tendency for psychiatric patients to misuse medication as a means to cope with problems, a lack of knowledge of the side affects of medication, as it reflects discharge planning, should provide for teaching about medications and documentation of patient's understanding about them. The nurse, doctor, and clinical pharmacist should develop a structured program for this function, delineating the roles and responsibility of each team member.

In examining the discharge diagnoses of the 79 patients, it was found that 25, or 32%, were diagnosed as having schizophrenia; 16, or 21%, depression; 10, or 12%, personality disorders; 5, or 6%, drug and alcohol abuse; and 20, or 26%, had no discharge diagnosis available in the record. The large number of schizophrenic patients is significant because of the characteristics of withdrawn patients, especially in regard to their difficulty in establishing and maintaining relationships (Brown & Fowler, 1971). Such factors need to be considered carefully for a follow-up treatment program.

The considerable number of patients' charts without a documented discharge diagnosis should be an immediate priority for the psychiatric team. There are important legal and accountability implications for any review of the quality of care that was given. Infor-

mation to referring agencies is also affected by the absence of a discharge diagnosis in the patient's record.

(3) Is There Evidence of Patient Teaching in the Chart?

There were minimal data on patient teaching. Only 10, or 12%, of the 79 charts reviewed had documentation with regard to patient teaching. There were 6 instances in which instruction about specific medication was given. Three patients were advised or taught the symptoms which should require further psychiatric intervention. Health knowledge is an expected outcome for hospitalized patients according to the Joint Commission on Accreditation of Hospitals, Nursing Audit Program (PEP Primer, 1974). Redman described patient education as a function of nursing practice and stated:

> Teaching is a highly versatile tool that can be used in all four modes of nursing intervention--to prevent, promote, maintain, and modify a wide variety of behavior in a receptive individual or group. (Redman, 1971, p. 574)

Therefore, the lack of documentation of patient teaching indicates that patient teaching either should be given immediate priority by the psychiatric in-patient treatment team, or that the professional staff should record instances of patient teaching in the patient record. One nurse had recorded that she had discussed alternate means of expressing feelings with the patient, which was one of the few recorded instances of patient teaching.

(4) Is there Documentation in the Patient's Record 24 Hours Prior to Discharge about his Behavior and Appearance?

Seventy-one, or 90%, of the 79 charts contained descriptive

statements in the nurses notes regarding the patient's behavior before discharge. A wide range of behavior was cited during the last 24 hours of hospitalization. Statements were also present as to the patient's physical appearance. Examples included comments that the patient was neatly dressed with hair combed, or in contrast, presented a disheveled appearance, unshaven, and with clothes wrinkled and dirty.

Descriptions of behavior in the nurse's notes ranged from comments that the patient was smiling, talking with other patients, and attending unit activities, to recording that the patient was crying, pacing the floor, and remaining in his own room with downcast facial expression. Since 1964, behavioral methods in health care settings have been tested with a wide range of patient management problems. Documentation of the patient's behavior is obviously primary data upon which treatment and rehabilitation programs can be based.

(5) Is There Evidence that the Patient and his Family were Involved in Planning for Discharge?

The only evidence available were statements that 31, or 41%, of the 79 patients did agree to accept the psychiatric follow-up appointment. In addition, in two patients' records it was documented that family conferences were held by members of the psychiatric team. According to the American Hospital Association (AHA) Patients' Bill of Rights (1973) the patient has a right to participate in his plan of care while in the hospital, including discharge planning. Family members should be included in planning for discharge, especially

when the patient is returning to a family unit. Documentation that such involvement did occur must be available for quality assurance review of the course of an individual's hospitalization and discharge planning. Since psychiatric nurses are scheduled to work in the evening when family members often visit, a nurse might be assigned to a specific patient and his family in order to explain the hospital treatment plan and discuss discharge plans; thus, providing a higher quality of psychiatric care.

In summary, a retrospective study was done involving 79 psychiatric in-patients' discharge charts to see what information was available to use as guidelines for discharge planning programs. The data obtained described the current patient population, identified areas where more information is needed, and suggested the need for further study in behavioral discharge and the affects of psychiatric treatment team intervention in discharge planning.

CHAPTER IV

SUMMARY

The provision of health care in the United States has become the nation's largest industry, with total yearly health expenditure approaching the $104 billion mark. In 1973, Americans spent $441 per capita or 7.7% of the gross national product on their health care needs, with the largest portion of this going toward hospital care (Cooper, 1974).

In view of the high cost of medical care, the health care industry is currently being bombarded with demands from many sources for quality assurance of their product. Delivery of health care, whether preventive, treatment of acute or chronic illnesses, or supervision of long-term health problems, should result in individuals receiving the highest quality of health care for their dollar.

The purpose of this research was to determine what written documentation exists in patients' charts after discharge from the hospital to support the premise that there is discharge planning of appropriate quality to withstand the scrutiny of objective review by monitoring agencies.

Quality assurance cannot be totally measured until there is a surveyed data base upon which criteria can be developed. A beginning data base for a quality assurance program for psychiatric patients should include evidence that appropriate planning regarding the

patient's discharge from the hospital occurred before he was discharged.

Primary consideration in this study was given to the following questions: (1) What admission data are available in the in-patient's record? (2) What constitutes discharge planning, including professional follow-up? (3) Is there evidence of patient teaching in the chart? (4) Is there documentation in the patient's record 24 hours prior to discharge about his behavior and appearance? (5) Is there evidence that the patient and his family were involved in planning for discharge?

The research design was a retrospective study in the form of a survey of information available in the patient's chart. Seventy-nine consecutive charts of psychiatric patients discharged from March 1, 1975 to May 1, 1975 were obtained from the Medical Records Department of the University of Utah Hospital on June 9, 1975. Completed charts in succession were pulled by the Medical Records staff, with two research associates assisting in collecting the tabulating data. Data were obtained from the Admission Sheet, Progress Notes, Nurses Notes, and Discharge Summary.

The retrospective study of the 79 psychiatric in-patients' discharge charts identified information available to use as guidelines for discharge planning programs. The data obtained described the current patient population, identified areas where more information is needed, and suggested the need for further study in behavioral discharge criteria, and the effects of psychiatric treatment team intervention in discharge planning.

In examining the discharge diagnosis of the patients, 32% were diagnosed as having schizophrenia, 21% depression, 12% personality disorder, 6% drug and alcohol abuse, and 26% had no discharge diagnosis. The data are significant in that characteristics of schizophrenic patients, especially in regard to their difficulty in establishing and maintaining relationships need to be considered for a follow-up treatment program (Brown & Fowler, 1971). The considerable number of patients' charts without a discharge diagnosis points to an immediate priority for the psychiatric team. There are important legal and accountability implications for any review of the quality of care. Information to referring agencies is also affected by the discharged diagnosis not being available.

Documentation of the patient's participation in his discharge planning and evidence of behavioral change at the time of discharge were most often not available in the charts. These are two important aspects of discharge planning especially in considering the patient's own rights and evaluating the hospital treatment plan. Family members need to be included in planning for discharge especially when the patient is returning to a family unit. As psychiatric nurses are scheduled to work in the evening when family members often visit, a nurse could be assigned to a specific patient and his family to explain the hospital treatment plan and to discuss discharge plans to provide quality of psychiatric care.

Ways to measure and compare behavior on admission and discharge, as well as methods for controlling the value system of the observer, are not available in the current psychology or psychiatric literature.

Some research questions are: (1) What behavioral changes are predictive of adjustment of the patient post-hospitalization? (2) What behaviors are indicators of further in-patient treatment? (3) Are the behavioral changes identified for discharge valid and reliable in other psychiatric hospital settings? (4) What influence did the treatment plan have on the expected behavior changes indicating quality of care?

However, further refinement of and adherence to present documentation systems in patient records are prerequisite to such research studies. The nursing audit is one such program which will be valuable for research, as well as for quality assurance reviews.

A further study is suggested by the need for patient teaching and patient participation in discharge planning. The psychiatric team could establish and conduct discharge planning groups with the patient and his family during hospitalization as suggested by Almond (1974). Group discussions could focus on feelings and problems of leaving the hospital and returning to their current living situation.

In such a program for discharge planning, each team member could concentrate on their own area of expertise in the group meetings. For example, the psychiatrist might discuss the need for medication and answer questions about specific medications. Different diagnoses and the possibility of recurrent symptoms might be discussed, as well we the support systems available to individuals upon discharge. The psychiatric nurse might discuss activities of daily living, especially as they relate to physical and emotional

needs and satisfactions. The social worker might discuss with the patient and his family the resources available for financial and social problems. Research into such a coordinated program of discharge planning would provide valuable information about the effectiveness of patient and family teaching, and about the problems encountered in implementing the program.

APPENDIX

ADMISSION AND DISCHARGE INFORMATION

Code Number _____

Admission Data

Age _____

Sex _____

Address--Salt Lake City ( ) Utah ( ) Out of State ( )_____

Mariatal Status-- M S D W

Religion-- LDS Catholic Protestant Other

Occupation _____

Educational Level _____

Private Welfare Other

Type of Admission-- 1. Scheduled ( ) Unscheduled ( )

Emergency Room ( ) Transfer ( )

2. Voluntary ( ) Non-Voluntary ( )

3. Day ( ) Evening ( )

Night ( )

4. Physician or Agency ( )

Admitting Diagnostic Impression _____

_____

_____

Length of Stay--Admission Date _____

Discharge Date _____

Discharge Data

Where Patient Discharged--	1. Home	( )	2. Nursing Home	( )
	3. Relative	( )	3. Other	( )
Professional Follow-up--	M.D. Appointment	( )	Community Mental Health Center	( )
	Private Counseling	( )	Other	( )
Activity--	Work	( )	School	( )
	Community Groups	( )	Other	( )

Evidence of Patient Teaching

Documentation in Patient's Record 24 Hours Prior to Discharge

Appearance

Behavior

Leave of Absence (LOF)

Evidence of Patient Involved in Discharge Planning

Prognosis

Discharge Diagnosis

Previous Admissions _____

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